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3-0900-19540-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Edina Care and Rehabilitation Center;
Survey Exit Date December 10, 2007

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on April 21, 2008. The OAH record closed at the conclusion of the conference that day.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, appeared on behalf of the Department of Health's Division of Compliance Monitoring (Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring, also participated in the conference.

Michelle Klegon, Esq., Voigt, Klegon & Rode, LLC, Suite 190 South, 2550 University Avenue West, St. Paul, MN 55114, appeared on behalf of Edina Care and Rehabilitation Center (the Facility). The following persons made comments on behalf of the Facility: Todd Carson, Executive Director; Nancy Lanz, Director of Nursing; Laura Kasel, RN; Charles Friend, LPN; Ellen Fischer, NP, Fairview Health Services; and Gretchen Cole, MD.

FINDINGS OF FACT

1. In November 2007, the Department of Health's Office of Health Facility Complaints (OHFC) conducted an abbreviated standard survey at Edina Care and Rehabilitation Center in connection with a complaint investigation. The complaint involved allegations that the Facility did not provide adequate care to prevent falls with regard to a resident who fell in the Facility and died later that day. During the investigative process, the OHFC investigator concluded that the Facility was not at fault for failing to prevent the fall, but that the Facility had failed to consult with a physician about the injury and had failed to monitor the Resident and intervene in a timely manner when the resident showed signs and symptoms of craniocerebral injury.[1]

2. On December 10, 2007, the Division issued a Summary Statement of Deficiencies to the Facility, citing violations of Tag F 157 (notification of changes) and Tag F 309 (quality of care) as a G-level deficiency involving actual harm that was isolated but not immediate jeopardy.[2]

3. In this IIDR proceeding, the Facility disputes those citations and asserts that they should be removed in their entirety.

Resident #1

4. Resident #1 was admitted to the Facility originally on September 16, 2007, at the age of 96 years, after abdominal surgery for endometrial cancer. Her history included two previous myocardial infarctions, and her primary diagnosis was congestive heart failure. After approximately one week, she was re-hospitalized for a pulmonary embolism. When she was readmitted to the Facility on September 29, 2007, she was taking medication for hypertension and Coumadin to thin the blood and prevent clots. The Coumadin increased the risk that the resident would bleed if she were to fall.[3] The Resident and her family provided advance directives not to resuscitate or intubate her.[4]

5. The Facility assessed the Resident as being at risk of falling and documented interventions in the care plan to prevent falls.[5]

6. On October 11, 2007, the Resident's physician gave orders to continue Coumadin 2 mg daily and to check the International Normalized Ratio (INR) results on October 15, 2007. The INR is a blood test to determine clotting time. A therapeutic INR result for prevention and treatment of venous thrombosis ranges from 2.0 to 3.0.[6]

7. On October 15, 2007, the Resident's INR result was 7.4, which is a critically high result. The Resident was seen by her nurse practitioner, who consulted with the Resident's physician. The physician gave orders to (1) hold the Coumadin, (2) give an injection of Vitamin K that night to bring down the INR result, and (3) re-check the INR in the morning.[7]

8. On October 16, 2007, the Resident's INR result was 7.9. The laboratory called this result to the facility that morning. The Resident was seen by her nurse practitioner, who again consulted with the Resident's physician. The physician gave orders to (1) hold the Coumadin, (2) give another injection of Vitamin K, and (3) re-check the INR in the morning.[8]

9. At about 1:45 a.m. on October 17, 2007, a nursing assistant found the Resident on the floor at the foot of her bed. The Resident had attempted to get up without calling for assistance, which she had never done before. The licensed practical nurse (LPN) who examined her found a five cm by three cm raised area on the back of her head. The Resident complained of localized pain on the back of her head but not of generalized headache. The Resident's blood pressure at 2:00 a.m. was 169/82, which was unusually high for her but not unprecedented.[9] The LPN placed an ice pack on the raised area and gave the Resident Tylenol for pain. The Resident went back to sleep almost immediately.[10]

10. The LPN telephoned the on-call physician within an hour of finding the Resident on the floor.[11] Although he documented a call to the physician, he did not make the notation until 7:30 a.m., when the nursing notes provide: "Information given to Dr. Cole on-call MD, no orders."[12] Contrary to the Facility's

policy, the LPN did not notify the on-call charge nurse or supervisor to conduct an assessment at the time of the injury or accurately document the time he spoke to the physician.

11. The on-call physician was not familiar with the Resident's medical history or the elevated INR results for the previous two days. The LPN did not inform the physician either that the Resident was taking Coumadin or that her INR had been elevated for the previous two days. He told the physician that the Resident had fallen, described the bump, and said the swelling was decreasing with the application of ice.

12. The LPN started a neuro-check assessment flow sheet. He checked the Resident's vital signs and neurological status at 2:15, 2:30, 3:30, 4:30, and 6:30 a.m. The Resident's blood pressure declined to her normal range by 2:30 a.m. and stayed in that range through the time of the check conducted at 6:30 a.m.[13]

13. The next neurological check was due at 8:30 a.m., at which time the Resident was eating breakfast in the dining room. The day shift nurse delayed the neurological check to allow the Resident to finish eating. At about 9:00 a.m, the laboratory telephoned with the Resident's most recent INR result of 6.2, which was again high but improved. The day shift nurse went down the hall to the nurse practitioner's office to inform her of the lab result, but the nurse practitioner was not there. The day shift nurse returned to the dining room and found the resident sitting with her head in her hands, complaining of a headache. The nurse gave the Resident some Tylenol and orange juice. At about 9:30 a.m. the nurse brought the Resident to her room, took her vital signs, and conducted the neurological assessment. She found that the Resident was somewhat confused, weaker, and less coordinated than usual, and the Resident's hand grip on the left side was slightly weaker than on the right. Her blood pressure was elevated at 163/77. The Tylenol did not relieve the Resident's headache, and the Resident reported she did not feel well. The nurse was concerned about the Resident's status and went to find the nurse practitioner.[14] The nurse practitioner is employed by Fairview Health Services, the same entity that employs the Resident's treating physician.

14. At 10:00 a.m., the nurse practitioner did a full neurological assessment of the Resident. The nurse practitioner described the Resident as being sleepy, but found the Resident's hand grips to be equal in strength and the exam to be within normal limits. She telephoned the Resident's physician, informed the physician of the fall and exam results, and they elected to watch the Resident closely and start hourly monitoring. The physician again ordered that the Coumadin be held, another Vitamin K shot be given that day, and the INR re-checked the next day.[15]

15. At 11:00 a.m., when the Resident's next status check was due, the Resident was in a care conference with staff and relatives to plan for her discharge from the Facility. The neurological check was not performed. During the care conference, the Resident complained of feeling increasingly sick. She

became noticeably weaker on the left side and returned to her room. At noon, the nurse practitioner wrote an order to send the Resident to the emergency room.[16]

16. The Resident died at the hospital at about 6:00 p.m. that evening. The family elected not to treat the injury. The death certificate attributes the cause of death to complications of blunt force craniocerebral injury from the fall.[17]

17. When interviewed in the course of the survey, the physician who was on call at the time of the injury said that if she had known the Resident was on Coumadin and had INRs greater than 7, she would have ordered the Resident to be sent to the emergency room for a CT scan of her head. The physician was not sure whether immediate treatment could have reversed the INR result in time to change the outcome for the Resident.[18]

18. Based on interviews and record review, the Division concluded that the Facility failed to consult immediately with the Resident's physician about the Resident's head injury; and when it did notify the physician about the injury, it failed to inform the physician about the Resident's anticoagulant therapy and elevated INR results. Based on these findings, the Department issued Tag F 157 (notification of changes). Tag F 157 alleges a violation of 42 C.F.R. § 483.10(b)(11), which provides in relevant part:

> Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—
>
> (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention[.]

19. The Department also issued Tag F309 (quality of care). Tag F 309 alleges a violation of 42 C.F.R. § 483.25, which provides in relevant part:

> Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

Tags F 157 and F 309 are supported by the facts and should be affirmed.

Dated: May 22, 2008.

s/Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

NOTICE

In accordance with Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

The Division's abbreviated survey resulted in two deficiencies. The Facility asserts that the Tags should be rescinded completely.

Tag F 157

Tag F 157 is based upon a violation of 42 C.F.R. § 483.10(b)(11), which requires the facility to consult with a resident's physician regarding any accident that results in injury and has the potential for requiring physician intervention. The 2567 alleges that the progress notes indicate the on-call physician was called at 7:30 a.m. and was not informed of the anticoagulation therapy or the elevated INR results. When interviewed during the survey, the LPN told investigators that he called the on-call physician within an hour of the injury.[19] During the IIDR, the physician confirmed that the LPN called her in the middle of the night, shortly after the fall had occurred.[20] The LPN failed to document properly when the call was made, but the Administrative Law Judge does believe the call was made within an hour of the injury. The Facility argues the deficiency should be removed because the LPN made a timely and accurate report to the physician of all information known to him.

Although the Facility did not violate 42 C.F.R. § 483.10(b)(11) by failing to consult the physician in a timely manner, it did violate this provision by failing to provide the physician with the information necessary to determine whether other interventions would be appropriate—namely, the critically high INR results for the previous two days. Assuming the LPN was not aware of these results or their significance, as he has said, he still should have called the on-call charge nurse or his supervisor, as the facility's policy required him to do, and that person should have recognized the significance of the issue and made certain that the physician was aware of it. The regulation requires not just that the physician be called, but that the caller "consults" by providing the physician with sufficient information to determine whether other interventions are necessary. Here, the

physician stated that had she known of the INR result, she would have sent the Resident to the hospital for an immediate CT scan of her head. The deficiency was properly cited.

Tag F 309

Tag F 309 is based upon an alleged violation of 42 C.F.R. § 483.25(h). Section 483.25 encompasses quality of care requirements that apply to long term care facilities. It generally requires that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."[21]

As reflected in the State Operations Manual (SOM), the intent of 42 C.F.R. § 483.25 is to ensure the resident does not deteriorate within the limits of a resident's right to refuse treatment and within the limits of recognized pathology and the normal aging process. "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment. In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present: an accurate and complete assessment; a care plan which is implemented consistently and based on information from the assessment; and evaluation of the results of the interventions and revising the interventions as necessary.[22] The Facility maintains that it provided all necessary care to the Resident and that her decline was unavoidable. The Facility points out that, as of approximately 10:00 a.m., the nurse practitioner had all the relevant information and, in consultation with the physician, elected to continue to monitor the Resident.

The Department maintains the nursing staff failed to intervene in a timely and appropriate manner and that, regardless of the decisions made by the nurse practitioner and physician, these failures to intervene by the Facility amount to a noncompliant nursing practice in violation of the applicable standard. On the night shift, the LPN failed to report the injury to the charge nurse, so the charge nurse did not assess the Resident, and the LPN failed to provide sufficient information to the physician (elevated blood pressures immediately after the injury, use of Coumadin, and abnormal INR results) to determine whether immediate intervention was necessary. In addition, the Department argues the day shift nurse should have intervened by contacting the nurse practitioner immediately to notify her of the INR test result for that day, the Resident's complaint of a headache and feeling sick, and the elevated blood pressure, weakness, confusion, and diminished hand grasp on the left side.

The issue here is not whether the Resident's death was the unavoidable consequence of either the fall, the complications caused by the amount of Coumadin in the Resident's system, or the family's decision not to treat the injury at the hospital. The issue is whether the Facility failed to provide all the necessary nursing care and services to maintain the Resident's highest practicable well-being. The Department has established that the cumulative actions outlined above amounted to a departure from compliance that precludes a finding that the Resident's decline was unavoidable. The cumulative delays on the night and day shifts in recognizing the severity of the potential injury to this Resident and in accurately communicating all the relevant information to her physician or nurse practitioner contributed, at minimum, to the pain and discomfort the Resident experienced before she was transported to the hospital. This is sufficient to establish actual harm.

After careful consideration of the record as a whole, the Administrative Law Judge concludes that the Division has demonstrated that the citation is supported by the facts and should be affirmed.

K.D.S.

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[1] MDH Ex. D.
[2] MDH Ex. D.
[3] MDH Ex. G-2b.
[4] MDH Ex. G-1a.
[5] MDH Ex. G-7, G-8.
[6] MDH Ex. G-11, G-25.
[7] *Id*.
[8] Ex. G-11, G-26.
[9] MDH Ex. G-19a. The Resident's usual blood pressure was in the range of 125-140/60-75, although it was higher on occasion. *Id*.
[10] MDH Ex. G-17a.
[11] Comments of Dr. Cole.
[12] *Id*.
[13] MDH Ex. G-18c; Comment of Laura Kasel.
[14] MDH Ex. G-20.
[15] MDH Ex. G-12; Ex. J-2.
[16] MDH Ex. G-18c; Ex. G-14.
[17] MDH Ex. I.
[18] MDH Ex. O.
[19] MDH Ex. M-2.
[20] Comment of Dr. Cole.
[21] 42 C.F.R. § 483.25.
[22] MDH Ex. F.